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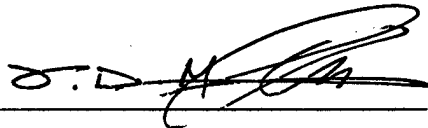
"The Role of the Plans, Operations and Medical Intelligence (POMI) Officer
on the Component and Unified-level Staff"

by


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A paper submitted to the Faculty of the Naval War College in partial
satisfaction of the requirements of the Department of Joint Military Operations.

The Contents of this paper reflect my own personal views and are not
necessarily endorsed by the Naval War College or the Department of the Navy.

Signature: 

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Abstract of -

The Role of the Plans, Operations and Medical Intelligence (POMI) Officer on the
Component and Unified Command-level Staff

Unprecedented threats in global disease endemicity, frightening advancements in weapons technology, and the horrific spectre of weapons of mass destruction (WMD) can and will have enormous impact on the health and welfare of the American Military without proper intelligence and planning considerations. In addition, changes in the fundamental way the Department of Defense (DoD) conducts business (greater participation in "operations other than war" (OOTW), particularly in efforts requiring significant humanitarian intervention), will require an enhanced emphasis on force and population protective measures traditionally considered to be in the realm of public health concerns.

The Plans, Operations and Medical Intelligence (POMI) Officer provides the theater-level Commander with vital information on health service support (HSS) requirements, based on theater medical intelligence estimates and an assessment of the potential public health impact on the conduct of operations, in that Commander's area of responsibility (AOR). This information is vital to operational commanders, as force protection and forces sustainment are critical elements in a geographic CINC's ability to achieve assigned national security objectives. This paper will focus on the roles and functions of the POMI Officer, and will assess the importance of this function on major theater staffs.

Introduction

Global disease endemicity has taken a significant turn for the worse in the last twenty-five years of the 20th Century. In the 1994 book "*The Coming Plague*,"¹ author Laurie Garrett discusses the re-emergence of diseases previously thought to be either eradicated or largely in-check by a combination of tight public health controls, modern immunizations, and marked improvements in the availability of global medical care. Smallpox, cholera, typhus, influenza, and even the plague have once again made headlines, largely in areas of the world which lack the ability to maintain a minimum standard of quality public health controls, provide adequate immunization programs, or maintain even the most modest of health care capabilities.

Even more frightening is Garrett's description of newly emerging diseases--heretofore unseen in the human population--that represent unprecedented challenges to the medical and scientific community. Ebola, Marburg, Lassa Fever, Machupo, Chickungaya, and--worst of all--HIV/AIDS (Human Immune-deficiency Virus/Auto-immune Deficiency Syndrome), have emerged as significant threats to the global population. In the short time since its discovery and identification, HIV/AIDS alone has achieved pandemic proportions. Given that there is, as yet, no known cure, and that the disease is always fatal, HIV/AIDS will likely surpass the "Black Plague" of the Middle Ages (1347-51) and the Great Influenza Pandemic of 1918 as the disease producing the greatest mortality of any known pathogen in human history. As of January, 1998, the World Health Organization (WHO) and the United Nations reports over 30 million *known*

¹ Garrett, Laurie, *The Coming Plague: Newly Emerging Diseases in a World out of Balance*. (New York: Farrar, Straus and Giroux 1994).

cases of HIV globally, with 16,000 new (officially reported) cases per day.² In comparison, at their peak, the Bubonic Plague was estimated to have killed over 25 million people in Central and Eastern Europe (only),³⁴ and the Influenza Virus of 1918 over 20 million globally.⁵

Whatever factors have contributed to these changes in global disease endemicity (theories include viral autogenesis and/or automutation, accumulated bacterial antibiotic resistance, public health degradation in under-developed countries, and even social and geo-political upheaval),⁶ the title of Garrett's work is both accurate and chilling: "*The Coming Plague*" may indeed be a harbinger of impending events in which the human population will struggle with disease and sickness in unparalleled form.

In addition to the threat that naturally-occurring organic disease presents, biological weapons of mass destruction (WMD) now present a method in which to deliver deadly pathogenic organisms amongst unsuspecting populations, whether military or civilian. Weaponized pulmonary Anthrax (*Bacillus Anthracis*) (99.5% fatal in non-protected, un-immunized populations receiving an inhalational dose of 10 microns or greater) and BOTOX (*Botulinum Toxicum*) (the most toxic substance known to man - 3 million times more toxic to humans than the chemical warfare agent Sarin)⁷ represent two

² "HIV/AIDS Statistics Prepared from UN Report," Newsweek Magazine, 29 December 1997-5 January 1998 (page un-numbered).

³ No official mortality records are available from this period in history. The European figures are considered most accurate because of global population concentrations at the time. Epidemiologists have estimated that the Plague outbreak between 1347-51 may have caused the deaths of more than 75 million people worldwide.

⁴ The Encyclopaedia Britannica, Micropaedia, "Plague," Volume 9, pp. 492-493.

⁵ Britannica, Micropaedia, "Influenza," Volume 6, pp. 311-312.

⁶ CNN Television Special, "A World out of Balance," 24 January 1998.

⁷ Department of Defense, Report on the Conduct of the Persian Gulf War (Washington: 1992), Chapter 1, p. 15.

of the most horrific methods of mass annihilation ever conceived. As with naturally occurring disease, it is impossible to see, smell or taste these agents once delivered in the ambient environment. With sufficient quantity and a clever (if not devious) delivery method, biological WMD have the potential to outstrip nuclear weapons in terms of geographic- and population-effective “bang for the buck.”

It is generally accepted by those involved in the military casualty estimate (CASEST) process that, since the Civil War, fully 70% of the total number of casualties of any given military campaign have been those in the category labeled Disease, Non-battle Injuries (DNBI).^{8,9} In addition to the impact of DNBI, the ability to provide adequate HSS capabilities to those injured as a direct result of hostile action is also of enormous importance to the Line commander, since force protection and force sustainment are critical in the operational commander’s ability to achieve assigned national security objectives. Minimizing the effects of force decimators such as injury, disease and biological WMD, then, must be of critical importance when planning for military campaigns. While the operational military commander has always been concerned with the presence and effects of disease, illness and injury upon his forces, insufficient attention has been paid to the role of medical planning and the impact of medical intelligence *prior* to the presentation of a medically-related event that demands the attention of our military leaders. Consequently, we have been forced to deal with these events in terms of *consequence management*, thereby obviating our chances to

⁸ Navy Department, Planning, Operations, and Medical Intelligence (Part B, Medical Intelligence), NWP 4-02.3, Department of the Navy, (Washington: 1993), 1-3.

⁹ The Disease, Non-battle Injury (DNBI) category encompasses all types of illness and injury less those suffered as a result of direct enemy contact, which are normally ballistic missile injuries.

either minimize or prevent potentially catastrophic events from impacting U.S. military personnel and force objectives.

It is precisely for these reasons that this paper seeks to argue the role and importance of the Navy's Plans, Operations and Medical Intelligence (POMI) Officer to the operational commander, principally on the Theater or Unified level of Command. By utilizing the knowledge and professional capabilities brought to the planning table by this small cadre of the Naval Service's medical department, Unified CINC's and Component Commanders can ensure the adequacy of HSS capabilities available for military operations, markedly reduce the number of casualties not related to hostile action, and be prepared to minimize the impact and effects of force decimators such as epidemic-level disease outbreaks and WMD.

A Developing Specialty

The requirement to plan for and provide medical support to personnel participating in military campaigns has existed for as long as men have fallen on the battlefield and disease has rampaged through the ranks of the warrior. It was not until the early part of the 20th Century, however, that a recognized specialty emerged to coordinate medical support for military operations.^{10,11} The first formal organizational efforts within the U.S. military occurred in 1919 when the 4th Marine Division returned to the United States after two years of intense combat in France. World War I had

¹⁰ "A History of Medical Operational Planning and Combat Service Support," Department of the Navy "Plans, Operations and Medical Intelligence (POMI)" Homepage, 21 November 1997, <<http://support1.med.navy.mil/bumed/med-00-1/pomi/default/htm/>> (27 January 1998).

¹¹ LCDR David Gray, MSC, USN. Many Specialties, One Corps: A Pictorial History of the Medical Service Corps, 1947-1997 (Donning Corporation, 1997), 119.

produced some of the most horrific levels of casualties in the history of modern warfare. Among many of the “revolutions in military affairs” (RMA) which contributed to the increased numbers of men killed or injured as a result of combat during the war was the introduction of chemical warfare agents, a terrifying and lethal presence on the battlefield. Upon their return to the United States, the Marines formed a study group at Quantico to develop lessons learned from their experiences in Europe. Recognizing that prior consideration of medical support requirements could positively impact on combat survivability, the Marine Corps recommended that the Department of the Navy create a Division of Medical War Planning within the Bureau of Medicine and Surgery (BUMED) in Washington, DC. The mission of this new division, which became fully operational in 1924, was to study the medical experiences of WWI, and to subsequently formulate basic doctrine and operational procedures for the provision of effective HSS in future wars.^{12,13}

Strategic-level medical support planning for the Navy and Marine Corps continued to be a province of BUMED as the “Operational Medicine Directorate” through WWII, Korea and Vietnam.¹⁴ During this time, operational and tactical-level HSS requirements remained a responsibility of the organic medical assets of individual components or units, and were usually addressed by the Senior Medical Officer (SMO) assigned (under the direction or advice of the BUMED Operational Contingency Directorate). While the Navy initiated combat HSS courses at Camps Lejeune and Pendleton in 1950 and 1951 (the Field Medical Service Schools) to train medical

¹² Department of the Navy “Plans, Operations and Medical Intelligence” Homepage.

¹³ CAPT William Frank, MSC, USN, Medical Service Corps Plans, Operations and Medical Intelligence Specialty Advisor, telephone conversation with author, 30 January 1998.

¹⁴ Ibid.

department personnel in combat casualty care and field medical supply,¹⁵ there remained no formal career track, nor training, for individuals dedicated to providing medical planning and intelligence expertise to operational commanders.

The 23 October 1983 bombing of the Marine Barracks in Beirut became the sad watershed event for the Department of Defense and the Navy Medical Department relative to the need for dedicated HSS planners and medical intelligence experts. With 241 deaths and 112 wounded in action (WIA),¹⁶ no single event had produced so many American casualties and required such significant medical support since Pearl Harbor. While the official Department of Defense report (also known as the *Long Commission* Report after its Chairman, Admiral Robert L. J. Long, USN) on the bombing praised the response of medical department personnel and the quality of the treatment provided to the wounded Marines and Sailors, the report was highly critical of the lack of adequate medical planning associated with the operations in Lebanon:

“Aeromedical evacuation and medical support plans do not recognize or provide for the peculiar and unique situation of CTF 61/62. USCINCEUR’s aeromedical evacuation plans and resources are designed for routine, peacetime operations. There was a lack of adequate numbers of experienced medical planning staff at all levels of the theater chain of command from CTF 61 up through COMSIXTHFLT, CINCUSNAVEUR, and USCINCEUR. In consequence, responsibility for medical support for the USMNF was diffuse, knowledge of regional medical facilities and potential sources of support was poor, and overall medical planning was inadequate.”¹⁷

¹⁵ Department of the Navy “Plans, Operations and Medical Intelligence” Homepage.

¹⁶ U.S. Department of Defense, Report of the DoD Commission on Beirut International Airport Terrorist Act, October 23, 1983 (Washington: 1984) 106.

¹⁷ Ibid, 111-112.

The *Long Commission Report* and the subsequent *Zimble Commission Report*,¹⁸ which were both briefed to Congress in 1984, echoed the findings of the DoD Commission regarding the inadequacies of medical planning, and, for the first time, recommended the formalization of a specialized community within the Service's medical departments to focus on medical planning for military operations.¹⁹ In 1986, the Department of Defense's *Medical Readiness Strategic Plan (MRSP)* reiterated the recommendations of the Long and Zimble Reports.²⁰ Using the *MRSP* as a catalyst, the Surgeon General of the Navy ordered that staffing be initiated to create a full-time specialty within the Health Care Administration section of the Medical Service Corps, and in 1991, the first 100 officers were designated as Plankowner's in the Plans, Operations, and Medical Intelligence (POMI) sub-specialty.^{21,22}

POMI Officers now provide medical planning and coordinate medical support requirements at the strategic, operational, and tactical level at all Joint and Combined Headquarters, Component and Numbered Fleet Headquarters, and Naval Platform and Medical Department activities. In addition, these officers manage the acquisition and administration of all finished medical intelligence (MEDINT) products.²³ The typical

¹⁸ CAPT William Frank, MSC, USN, telephone conversation with author, 30 January 1998.

¹⁹ Ibid.

²⁰ U.S. Department of Defense, *Medical Readiness Strategic Plan 1986* (Washington: 1986).

²¹ The Department of the Army (DoA) has had a subspecialty known as "Medical Operations and Readiness" (70-Hotel) within the Medical Service Corps. The 70-Hotel subspecialty remains the equivalent to the DoN POMI. To date, the Department of the Air Force (DoAF) does not have a dedicated equivalent of the POMI or 70-Hotel. Instead, Medical or Biological Service Corps Officers desiring experience in operational readiness/medical planning can do so throughout their careers. They are, however, mandated to tours in military treatment or research facilities in order to maintain eligibility for promotion.

²² CAPT William Frank, MSC, USN, telephone conversation with author, 30 January 1998

²³ "Plans, Operations and Medical Intelligence (POMI) Officer Specialty Brief," *Department of the Navy Medical Service Corps Homepage*, July, 1997. <<http://support1.med.navy.mil/bumed/med-00-1/00msc/default/htm/>> (27 January 1998).

career progression of POMI Officers is depicted in Figure 1-

1. Navy Medical Service Corps Officers desiring to remain in the plans, operations and medical intelligence arena throughout their career may now do so (a critical recommendation made in the most recent DoD MRSP) without negatively impacting on their upward career mobility.²⁴ The benefit of such an arrangement is significant, in that POMI officers competing for assignments at the highest level of the DoD (OSD, JCS, Unified Staffs, DIA, etc.) will possess the necessary professional acumen to competently advise authorities on issues of strategic importance.

Training for assignments in the POMI community is accomplished at both the Joint and Service Component level. Concurrent with the creation of the POMI Community within the DoN as a result of the recommendations in the 1986 *MRSP*, the Deputy Director for Medical Readiness (DDMR) (J4 Directorate of the Joint Staff) initiated the first formal training program in medical plans, operations and intelligence -- the Joint Medical Planners Course (JMPC). Officers from each of the services attend this program to develop the skills necessary to function at the operational level and above. Other Joint Courses include the Armed Forces Medical Intelligence (AFMIC) Course, Combat Casualty Care Course (C4), The Medical Effects of Nuclear, Biological, and Chemical (NBC) Agents, and the Chemical/Biological Weapon Proliferation Course.

POMI Career Progression

- 03 (Entry Level) - MTF Contingency Plans Manager; CATF Medical Regulator; #d Fleet/MEF/PHIBGRU Medical Plans & Intel
- 04 (Mid-Level) - Component Command Medical Plans & Intel; OPNAV/HQUSMC/ BUMED, Intermediate-level School (CNC&S)
- 05 (Senior-level) - Unified Command Medical Plans & Intel; Joint Staff; OSD
- 06 (Executive-level) - Senior Medical Planner, Unified Commands; CO AFMIC; Medical Planner of the Navy/USMC; Senior-level School

Figure 1-1

²⁴ U.S. Department of Defense, Medical Readiness Strategic Plan 1995-2001 (Washington: 1995) A-10.

The Navy offers entry and mid-level career training through the basic and advanced POMI Course, the Medical Regulating Program, and the Strategic Medical Contingency Course (SMRCC). In addition to the military courses offered during their careers, POMI Officers are encouraged to pursue graduate-level studies in areas such as Public Health, National Security and Strategic Studies (available through the Service Colleges and the Navy's College of Naval Command and Staff), International Affairs, and Health Care Policy.

Roles and Capabilities of the POMI Officer -

Part 1 - Medical Intelligence:

Building the foundation for an adequate health service support structure requires a thorough and exhaustive assessment of conditions in the area of operations (AOO). As in the process of intelligence preparation of the battlefield, which seeks to reduce uncertainties concerning the enemy, weather and terrain,²⁵ the medical intelligence (MEDINT) assessment reduces the uncertainties posed by potential medical threats in the area in which U.S. forces will operate. Joint Publication 1-02 defines MEDINT as follows:

“Medical intelligence is that category of intelligence resulting from the collection, evaluation, analysis, and interpretation of foreign medical, bio-scientific, and environmental information which is of interest to strategic planning and to military medical planning and operations for the conservation of the fighting strength of friendly forces and the formation of assessments of foreign medical capabilities in both military and civilian sectors.”²⁶

²⁵ Department of the Army, Intelligence Preparation of the Battlefield, FM 34-130 (Washington: 23 May 1989) 1-1.

²⁶ Joint Chief of Staff, DoD Dictionary of Military and Associated Terms, Joint Pub 1-02 (Washington: 23 March 1994).

The Naval Warfare Publication "Planning, Operations, and Medical Intelligence" (NWP 4-02.3) defines the following areas as necessary for consideration when formulating a medical intelligence estimate for operational commanders:

1. Endemic or epidemic diseases in the area of operations, public health standards and capabilities, and the quality and availability of health services.
2. Medical supplies, medical services, medical treatment facilities, and the number of trained HSS personnel.
3. Location-specific diseases, strains of bacteria, insects, harmful vegetation, snakes, fungi, spores, and other harmful organisms.
4. Foreign animal and plant diseases, especially those diseases transmissible to humans.
5. Health problems relating to the use of local food supplies and water.
6. Medical effects of and prophylaxis against weaponized chemical and biological agents and radiation.
7. The impact of newly developed *foreign* weapons systems and capabilities as they relate to casualty production.
8. The enemy force related to its state of health and fitness, medical support capabilities, availability of professional health care providers, and its use of special antidotes or medical treatment plans.
9. Environmental factors in an area of operations such as altitude, heat, cold, and swamps that in some way may effect the health of the command or HSS operations.²⁷

²⁷ NWP 4-02.3, Part B, p. 1-3.

Finished medical intelligence products are normally provided by the Armed Forces Medical Intelligence Center (AFMIC), a division of the Defense Intelligence Agency (DIA) which is located at Fort Detrick, Maryland. It is important to note the following points, however, regarding MEDINT: 1) AFMIC is a remarkably good source for operational commanders to develop a baseline MEDINT assessment of their theater of operations; but, it should be remembered that the areas of concern listed above are often very fluid in nature, and can dramatically change the existent data base of information available through AFMIC and other U.S. intelligence sources. 2) POMI Officers must use every means available to determine an accurate theater MEDINT assessment, including the use of any other available sources of medical information (examples of such “other” medical information sources include the Centers for Disease Control (CDC), the World Health Organization (WHO), and NGOs/PVOs providing humanitarian assistance in the AOO). 3) The POMI Officer represents the staff expert capable of making a qualitative evaluation of the (potential) medical concerns of a commander’s AOO; it is vital that the POMI is included in forward assessment teams in order to have an “eye’s-on” view of the AOO.

Part 2 - Medical Planning

It is based on the information provided by the MEDINT assessment that the POMI officer formulates the health service support plan for the course of operations. After determining the Population-at-Risk (PAR) and Casualty Estimate (CASEST),²⁸ the

²⁸ The PAR and CASEST figures are provided to the theater medical planner through the coordinated efforts of the J1, J2, and J3, based on the total number of personnel participating in operations (J1), enemy threat to friendly forces (J2), and operational (battle) intensity (J3).

first priority of the medical planner is the utilization of the Medical Analysis Tool (MAT), a computerized requirements modeling system which determines:

- a. Theater Bed Requirements (Echelon III through V) to support the PAR and CASEST (broken-out by surgical, intensive care, and non-surgical support requirements);
- b. Theater Tactical and Strategic Aeromedical Evacuation Requirements (including personnel supporting MEDEVAC operations);
- c. Detailed Medical Personnel Requirements (by specialty);
- d. Theater Blood Requirements; and,
- e. Theater Class VIII (Medical) Logistics Requirements (above organic sustainment capabilities of units deploying to the AOO).^{29,30}

Obtaining this information from the MAT program and applying it in logical fashion does not conclude the efforts of the POMI Officer, and it most certainly does not ensure the adequacy of the HSS capabilities to support the course of anticipated operations. It is here that the experience of career personnel dedicated to the medical planning and intelligence arena will pay its largest dividend to the operational commander: armed with the raw information provided by the MAT and the knowledge of theater conditions provided by the MEDINT assessment, the POMI must recommend how the HSS system should be designed, integrated with theater assets, and employed to support operational casualty streams, provide for force protection and sustainment, and hence help ensure the commander's achievement of assigned national security objectives.

²⁹ The Medical Analysis Tool (MAT) replaced the JOPES Medical Planning Module (MPM) in 1997 as the only DoD approved, standardized system to be used by the Unified Commands and Joint Staff to predict wartime medical requirements.

³⁰ Medical Readiness Strategic Plan, 1995-2001, 17-18.

Recommendations and Conclusion -

What makes the Navy POMI unique, and the officer of choice at the Component and Unified level of operations? Unlike other medical department personnel who spend their careers in the clinical or administrative environment, and may step in to the operational arena periodically as assignments may require, POMI Officers are dedicated throughout their careers to the provision operational medical support. POMI Officers are not experts in *clinical* medical requirements; that remains the province of the Command Surgeon. They are, however, the experts of choice in developing MEDINT assessments and HSS requirements, and integrating these capabilities successfully into the operational and strategic planning process.

Force protection and force sustainment: These phrases are vital to the operational commander's lexicon. Not only do they equate with a CINC's ability to master assigned objectives, they equate with his ability to safeguard and preserve the CINC's most precious commodity--American Soldiers, Sailors, Airmen and Marines. The purpose of this paper is to demonstrate to operational commanders the availability of a specialized group of medical professionals who can significantly enhance their ability to protect their military charges from force decimators such as injury, disease, WMD, and inadequate HSS structure. As final points, the following recommendations are provided:

1. The threat of WMD--particularly from the use of biological and chemical agents--is now considered the most significant threat to U.S. military forces in the world. The situation is exacerbated by the proliferation of chemical and biological agents among terrorist factions, who find it easy to procure and/or produce the materials for these

horrific weapons. Because of the inherent difficulties in detecting the employment of these agents (particularly bio-weapons), our most diligent intelligence and counter-proliferation efforts may fall short in providing the necessary means to deter their use.³¹ In as much, it is imperative that operational commanders at the Unified and Component levels rely upon the POMI as the principal staff expert on chem-bio agents, their effects on the human physiology, and the HSS requirements necessary to support U.S. personnel faced with the threat of exposure to a C-B event.

2. In an era where U.S. military forces will be more and more frequently called upon to provide support in "operations other than war" (OOTW), Unified and Component Commanders can likewise expect to have to provide unprecedented levels of humanitarian support. Since 1982, the U.S. military has participated in 24 separate events that were considered OOTW requiring significant humanitarian support efforts.³² More often than not, concurrent with the requirement to provide humanitarian support is the requirement to provide--or at least coordinate--medical support to an affected population. In the OOTW environment, then, the POMI should function in a close advisory capacity to the responsible Line Commander to ensure adequate HSS are available not only to deployed U.S. personnel, but potentially to coalition partners and enormous civilian populations. Even if the decision is made by the NCA not to deploy significant humanitarian and medical assets to an OOTW, at a minimum the POMI represents the most significant staff expertise to help indigenous medical personnel

³¹ Office of the Secretary of Defense, Proliferation: Threat and Response (Washington: April 1996).

³² U.S. Department of Defense, 1997 Defense Almanac (American Information Service: 1997) 41-42.

design or coordinate a functioning medical support system to provide care for the local population.

3. Operational commanders must recognize the following truism: *The quality of public health declines proportionately to the increased level of hostile military activity in any given area.* With the advent of real-time media coverage, it will be possible to not only track the horrors of war among combatants, but also the collateral effects of military operations against civilian populations not actively engaged in the conflict. As pointed out in the article entitled “The Role of Law in the Gulf War: Protection of Civilians or Legitimization of Violence?”, the Iraqi People have suffered enormously since the end of the Gulf War, principally because of a degradation of public health capabilities that directly resulted from what were, at the time, the destruction of legitimate targets by U.S. and Coalition forces (electrical plants, water purification facilities, sewage treatment plants, etc.). Morbidity and mortality have sky-rocketed in Iraq, sadly in greatest proportion in the pediatric population.³³ In the future, the desired end-state of military operations may be much more far-reaching than the terminus of combat operations and the re-deployment of U.S. military forces. The national ethos of the American People may demand our assistance in obviating the suffering of our former enemies. The requirement for operational commanders to be acutely aware of and prepared to deal with the consequences of large-scale public health declines can be greatly enhanced by the expertise organic to the POMI community.

³³ John O’Laughlin, Tom Mayer and Edward S. Greenberg, ed., War and its Consequences: Lessons from the Persian Gulf Conflict, (Harper Collins, 1994), Chapter II: Bomb Now, Die Later: The Role of Law in the Gulf War: Protection of Civilians or Legitimization of Violence?, by Christopher Af Jochnick and Roger Normand

4. Finally, if we are to collectively lessen the impact of disease, illness and injury on our forces through pre-meditative attempts at force protection, it behooves the DoD *in toto* to consider issues of medical intelligence, public health, and health services support planning at the academic centers of the military, where future leaders--CINCs and Component Commanders--can be inculcated in the foundations of these vital requirements. The Naval War College has approved, for example, the establishment of the "VADM Joel T. Boone Chair of Health Service Support," to allow mid- and senior-grade officers exposure to the principals of operational medical support. Perhaps the establishment of a course on "War and Public Health" at the Service Academies would be of sufficient means to begin exposing our future service leaders to medical issues and their impact on all military operations.

In Navy Medicine, the catch-phrase of the 1990's has been "Readiness is True North." The POMI community, in turn, likes to say that "If Readiness is True North, then the POMI's are at the point of the compass." This community indeed brings an important and valuable contribution to the table of the operational commander. Proper utilization of this asset, particularly in an era witnessing unprecedented threats from global disease endemicity, frightening advancements in weapons technology, and the mortifying fear aroused by WMD, can and will make a substantive difference on the health, welfare, and survivability of the world's premier fighting force.

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Glossary of Acronyms

AFMIC - Armed Forces Medical Intelligence Center	NWP - Naval Warfare Publication
AOO - Area of Operations	OOTW - Operations Other than War
AOR - Area of Responsibility	OPNAV - Office of the Chief of Naval Operations
BUMED - Bureau of Medicine and Surgery	OSD - Office of the Secretary of Defense
C4 - Combat Casualty Care Course	PAR - Population-at-Risk
CASEST - Casualty Estimate	PHIBGRU - Amphibious Group
CATF - Combined Amphibious Task Force	POMI - Plans, Operations and Medical Intelligence
CDC - Centers for Disease Control	PVO - Private Volunteer Organization
CINC - Commander-in-Chief	SMO - Senior Medical Officer
CINCUSNAVEUR - Commander-in- Chief United States Naval Forces Europe	SMRCC - Strategic Medical Readiness and Contingency Course
CNC&S - College of Naval Command and Staff	USCINCEUR - United States Commander-in-Chief Europe
COMSIXTHFLT - Commander, Sixth Fleet	USMC - United States Marine Corps
CTF - Combined Task Force	USMNF - United States Multi-national Force
DDMR - Deputy Director for Medical Readiness, J4	WHO - World Health Organization
DIA - Defense Intelligence Agency	WIA - Wounded-in-Action
DNBI - Disease, Non-battle Injury	WMD - Weapons of Mass Destruction
DoD - Department of Defense	
DoN - Department of the Navy	
HIV/AIDS - Human Immune Deficiency Virus/Auto-immune Deficiency Syndrome	
HQUSMC - Headquarters, United States Marine Corps	
HSS - Health Service Support	
JCS - Joint Chiefs of Staff	
JMPC - Joint Medical Planners Course	
MAT - Medical Analysis Tool	
MEDEVAC - Medical Evacuation	
MEDINT - Medical Intelligence	
MEF - Marine Expeditionary Force	
MRSP - Medical Readiness Strategic Plan	
MTF - Military Treatment Facility	
NBC - Nuclear, Biological and Chemical	
NGO - Non-governmental Organization	